STATE OF IDAHO
DEPARTMENT OF INSURANCE
700 WEST STATE STREET, 3rd FLOOR
PO BOX 83720
BOISE, ID 83720-0043

FOR DEPARTMENT USE ONLY	0560 1025 1315-10 TOTAL _____

STATEMENT OF TAXES AND FEES

REGISTERED SELF-FUNDED HEALTH CARE PLANS

PLAN NAME	REGISTRATION NO.
MAILING ADDRESS	YEAR ENDING DATE

RECAP OF TAXES AND FEES

NUMBER OF BENEFICIARIES COVERED PER MONTH:

JANUARY	_____	JULY	_____
FEBRUARY	_____	AUGUST	_____
MARCH	_____	SEPTEMBER	_____
APRIL	_____	OCTOBER	_____
MAY	_____	NOVEMBER	_____
JUNE	_____	DECEMBER	_____

TOTAL BENEFICIARIES _____

1. TOTAL TAXES = TOTAL BENEFICIARIES_____ X .04 $_____

2. ANNUAL CONTINUATION FEE IDAPA 18.01.44.03.a.viii. IDAHO CODE 41 - 4011(3) $ 500.00
   Payment of fee must be included.

3. BALANCE DUE - Make check payable to: **Idaho Department of Insurance** $_____
   There will be a $20.00 charge on all returned checks. Idaho Code § 28-22-105
   Your canceled check is your receipt.

Under penalty of perjury, I declare that this statement (including any accompanying schedules and statements) has been examined by me and to the best of my knowledge and belief is a true, correct, and complete return.

Contact Person

Signature of Trustee Date

( ) Telephone Number Ext.

Name and Title (Type or Print)

INS-PTX-TRSF (11-08)